

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **35843**
Registrar's No. **10212**

FILED DEC 31 1945
Registration District No. _____

Primary Registration District No. _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis County

(c) City or town Clayton
(If outside city or town limits, write "RURAL")

(d) Street No. 619 Forest Court
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James L. Scott

3. (b) If veteran, name war no unknown

3. (c) Social Security No. 295-09-7806

4. Sex Male **5. Color or race** White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elba Scott

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 20 1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>4</u>	<u>5</u>	hr. _____ min.

9. Birthplace _____
(City, town, or county) Pennsylvania
(State or foreign country)

10. Usual occupation Plant Comptroller

11. Industry or business General Cable Corp.

12. Name William Scott

13. Birthplace Unk Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Stewart

15. Birthplace Unk Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs James L. Scott

(b) Address 619 Forest Court Clayton 5 Mo.

17. (a) Removal _____ **(b) Date thereof** 11-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pittsburg, Pennsylvania

(a) Signature of funeral director Fred M. Williams

(b) Address 4535 Washington Blvd.

19. (a) NOV 26 1945 **(b)** _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25 year 1945 hour 9 minute _____ P. M.

21. I hereby certify that I attended the deceased from Nov 23 1945, 1945 to Nov 25 1945

that I last saw him alive on November 25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Lewis Lattmann (M. D. or other) _____

Address 7501 Crosswell Dr. Date signed Nov 26 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed

J. W. Wilkinson

Licensed Embalmer No.

3575

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.